INSURANCE CODE

TITLE 8. HEALTH INSURANCE AND OTHER HEALTH COVERAGES

SUBTITLE E. BENEFITS PAYABLE UNDER HEALTH COVERAGES

CHAPTER 1356. MAMMOGRAPHY

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 1065, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1356.001. DEFINITIONS. In this chapter:

(1) "Breast tomosynthesis" means a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.

(1-a) "Diagnostic mammogram" means an imaging examination designed to evaluate:

(A) a subjective or objective abnormality detected by a physician in a breast;

(B) an abnormality seen by a physician on a screening mammogram;

(C) an abnormality previously identified by a physician as probably benign in a breast for which follow-up imaging is recommended by a physician; or

(D) an individual with a personal history of breast cancer.

(2) "Low-dose mammography" means:

(A) the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, and screens, with an average radiation exposure delivery of less than one rad mid-breast and with two views for each breast;

(B) digital mammography; or

(C) breast tomosynthesis.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 816 (H.B. 1036), Sec. 2, eff.

September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1356 (H.B. 170), Sec. 1, eff. September 1, 2019.

Sec. 1356.002. APPLICABILITY OF CHAPTER. (a) This chapter applies to a health benefit plan, including a small employer health benefit plan written under Chapter 1501 or coverage that is provided by a health group cooperative under Subchapter B of that chapter, that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842;

(3) a health maintenance organization operating under Chapter 843;

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844;

(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846;

(6) a stipulated premium company operating under Chapter 884;

(7) a fraternal benefit society operating under Chapter 885;

(8) a Lloyd's plan operating under Chapter 941; or

(9) an exchange operating under Chapter 942.

(b) This chapter applies to coverage under a group health benefit plan described by Subsection (a) provided to a resident of this state, regardless of whether the group policy or contract is delivered, issued for delivery, or renewed within or outside this state.

(c) This chapter applies to group health coverage made available by a school district in accordance with Section 22.004(b), Education Code.

(d) This chapter applies to a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91, Labor Code.

(e) Notwithstanding Section 22.409, Business Organizations Code, or any other law, this chapter applies to a church benefits board established under Chapter 22, Business Organizations Code.

(f) Notwithstanding Section 75.104, Health and Safety Code, or any other law, this chapter applies to a regional or local health care program established under Chapter 75, Health and Safety Code.

(g) Notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law, this chapter applies to:

(1) a basic coverage plan under Chapter 1551;

(2) a basic plan under Chapter 1575;

(3) a primary care coverage plan under Chapter 1579; and

(4) basic coverage under Chapter 1601.

(h) Notwithstanding any other law, a standard health benefit plan provided under Chapter 1507 must provide the coverage required by this chapter.

(i) To the extent allowed by federal law, this chapter applies to:

(1) the state Medicaid program operated under Chapter 32, Human Resources Code; and

(2) a Medicaid managed care program operated under Chapter 533, Government Code.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 816 (H.B. 1036), Sec. 2, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1356 (H.B. 170), Sec. 2, eff. September 1, 2019.

Sec. 1356.003. APPLICABILITY OF GENERAL PROVISIONS OF OTHER LAW. The provisions of Chapter 1201, including provisions relating to the applicability, purpose, and enforcement of that chapter, construction of policies under that chapter, rulemaking under that chapter, and definitions of terms applicable in that chapter, apply

to this chapter.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Sec. 1356.004. EXCEPTION. This chapter does not apply to a plan that provides coverage only for a specified disease or for another limited benefit.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

The following section was amended by the 87th Legislature. Pending publication of the current statutes, see S.B. 1065, 87th Legislature, Regular Session, for amendments affecting the following section.

Sec. 1356.005. COVERAGE REQUIRED. (a) A health benefit plan that provides coverage to a female who is 35 years of age or older must include coverage for an annual screening by all forms of low-dose mammography for the presence of occult breast cancer.

(a-1) A health benefit plan that provides coverage for a screening mammogram must provide coverage for a diagnostic mammogram that is no less favorable than the coverage for a screening mammogram.

(b) Coverage required by this section:

(1) may not be less favorable than coverage for other radiological examinations under the plan; and

(2) must be subject to the same dollar limits, deductibles, and coinsurance factors as coverage for other radiological examinations under the plan.

Added by Acts 2003, 78th Leg., ch. 1274, Sec. 3, eff. April 1, 2005.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 816 (H.B. 1036), Sec. 4, eff. September 1, 2017.

Acts 2019, 86th Leg., R.S., Ch. 1356 (H.B. 170), Sec. 3, eff. September 1, 2019.